Surgical Specialists of Carolina

RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: _____

BY SIGNING BELOW, I AUTHORIZE Surgical Specialists of Carolina TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	YES	NO	_____
CHILDREN	YES	NO	_____
IN-LAWS	YES	NO	_____
CAREGIVERS	YES	NO	_____
PARENTS	YES	NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

SURGICAL SPECIALISTS OF CAROLINA MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	YES	NO
WORK	YES	NO
RELATIVE	YES	NO

PATIENT SIGNATURE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP			
SPOUSE	YES	NO	_____
RELATIVE	YES	NO	_____
CAREGIVER	YES	NO	_____

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT SURGICAL SPECIALISTS OF CAROLINA WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.